

Individuals completed the first session of the assessment	1591	AVAP First Session Interview – Detail by Need for Change Status	
Of those individuals, 86% were unemployed	1362		
Of the unemployed individuals, 79.2% expressed a strong or urgent need to become employed	1079	61% Experience periods of sadness or depression	44% (478) grew up in a household receiving public assistance
		63% have received MH trx in past	
		24% currently receive MH trx	
10.3% of unemployed individuals were unsure about becoming employed.	140	73% Experience periods of sadness or depression	51% (71) grew up in a household receiving public assistance
		77% have received MH trx in past	
		37% currently receive MH trx	
10.5% of unemployed individuals did not want to become employed.	143	67% Experience periods of sadness or depression	41% (59) grew up in a household receiving public assistance
		74% have received MH trx in past	
		39% currently receive MH trx	

ANDREW SOLOMON

ARTICLES

BOOKS

ABOUT

EVENTS

search term here

A Cure for Poverty

What if you could help end people's economic problems by treating their depression?

Wendy was born just below the poverty line, where she spent the next 30 years of her life. These were grim times for her. When she was 6, a disabled friend of her alcoholic grandmother began abusing her sexually. In seventh grade she began to withdraw. "I felt there was no reason to go on," she says. "I did my schoolwork and everything, but I was not happy in any way. I would just stay to myself. Everyone thought I couldn't talk for a while, because for a few years there I wouldn't say anything to anyone." Her first boyfriend, from her neighborhood in the slums around Washington, was physically and verbally brutal. After the birth of her first child, when she was 17, she managed to "escape from him, I don't know how." Not long after, Wendy, a petite African-American woman with grave eyes and a wide mouth, was raped by a family friend. Soon after that, under pressure from her family, she married a man who was also abusive. She had three more children by him in the next two years. "He was abusing the children too, even though he was the one who wanted them, cursing and yelling all the time, and the spankings, I couldn't take that, over any little thing, and I couldn't protect them from it." She also had to assume responsibility at this time for her sister's children, because the sister was addicted to crack cocaine.

Wendy began to experience major depression — not simply the generalized despair that might be expected of someone in her position, but an organic illness that was utterly disabling: "I'd had a job, but I had to quit because I just couldn't do it. I didn't want to get out of bed, and I felt like there was no reason to do anything. I'm already small, and I was losing more and more weight. I wouldn't get up to eat or anything. I just didn't care. Sometimes I would sit and just cry, cry, cry. Over nothing. I had nothing to say to my own children. After they left the house, I would get in bed with the door locked. I feared when they came home, 3 o'clock, and it just came so fast. I was just so tired." Wendy began to take pills, mostly painkillers. "It could be Tylenol or anything for pain, a lot of it, though, or anything I could get to put me to sleep."

Finally one day, in an unusual show of energy, Wendy went to the family-planning clinic to get a tubal ligation. At 28, she was responsible for 11 children, and the thought of another one petrified her. She happened to go in when Jeanne Miranda, an associate professor of psychiatry at Georgetown University, was screening subjects for a study of poor people suffering from depression. "She was definitely depressed, about as depressed as anyone I'd ever seen," recalls Miranda, who gave Wendy the diagnosis and swiftly put her into group therapy. "It was a relief to know there was something specific wrong," Wendy says. "They asked me to come to a meeting, and that was so hard. I didn't talk. I just cried."

On any given day, roughly 18 million Americans meet the diagnostic criteria for mood disorders, meaning that they have reached an emotional low that impairs their functioning. Three million of those are children. Depression claims more years of useful life in America than war, cancer and AIDS put together, according to the World Health Organization's World Health Report 2000. And the indigent depressed are among the most severely disabled populations in this country. There are no reliable figures on how many of these people there are, but 13.7 percent of Americans live below the poverty line, and according to one recent study, about 42 percent of heads of households receiving Aid to Families With Dependent Children meet the criteria for clinical depression — more than three times the national average.

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Despite the extended debates in the last decade about depression's causes, it seems fairly clear that it is usually the consequence of a genetic vulnerability activated by external stress. Most people have some level of genetic vulnerability. Those with a high vulnerability can have it triggered by a fairly minor event; those with a low degree of vulnerability will be triggered only by more significant trauma. But among the indigent, the traumas are so terrible and so frequent, says Miranda, that searching for the depressed among them is like checking for emphysema among coal miners. The depression rate among the poor is the highest of any social grouping in the United States, so high that many don't notice or question it. "If this is how all your friends are," Miranda says, "it begins to have a certain terrible normality to it."

In travels to some fairly remote parts of the world, I found that much the same rules apply to trauma-prone populations everywhere. Survivors of the Khmer Rouge in Cambodia have an extremely high rate of depression. Phaly Nuon, a Cambodian woman who has founded a treatment center and an orphanage in Phnom Penh, describes seeing women who had made it through the horrific years of war only to become so depressed afterward that they let their own children starve to death in the resettlement camps. She said that these women, born to grim lives of rural poverty, had been disabled by what they had seen. I found similar phenomena among the Inuit of Greenland, tribal peoples in Senegal, the urban poor in Russia. Depression rates are very high all around the world among people with hard lives, and these people tend to be disproportionately poor.

Depression can be difficult enough to recognize among the affluent, but if you're way down the socioeconomic ladder, the signs may be even harder to distinguish. When someone in the middle classes becomes depressed and suddenly finds that he can't function at a high level, can't work, begins to withdraw, he is likely to attract the attention of friends and family members. But if you're poor, these symptoms don't seem much of a change. Your life has always been lousy; you've never been able to get or hold a decent job; you've never expected to accomplish much; and you've never entertained the idea that you have much control over what happens to you.

The depressed poor perceive themselves to be supremely helpless — so helpless that they neither seek nor embrace support. This means that most people who are poor and depressed stay poor and depressed. Poverty is depressing, and depression, leading as it does to dysfunction and isolation, is impoverishing.

The poor tend to have a passive relationship to fate: their lack of self-determination makes them far more likely to accommodate problems than to solve them (they are, by extension, far less likely to commit suicide than are the empowered). This passivity also causes them to accept treatment as passively as they accept their own misery, which means they can be helped through programs of assertive outreach. Medicaid recipients qualify for extensive care, but they have to claim it, and depressed people do not exercise rights or claim what should be theirs, even if they have the rare sophistication to recognize their own condition. They can be saved only by pressing insight onto them, often through muscular exhortation.

Miranda is one of a small group of therapists who embrace this idea of assertive intervention. "If you treat their depression," says Miranda, "you give them a new world."

Wendy was not an easy subject at first. On more than one occasion a member of Miranda's staff had to go to her house and persuade her to come out. She said she had no time. She was taciturn and kept people at a distance. "Then they kept calling, telling me to come, pestering and insisting, like they wouldn't let go. I didn't like the first meetings. But I listened to the other women and realized that they had the same problems I was having, and I began to tell them things. I'd never told anyone those things. And the therapist asked us all these questions to change how we thought. And I just felt myself changing, and I began to get stronger."

After two months of group therapy, Wendy told her husband that she was leaving. "There was no arguing because I just didn't argue back. I just told him, 'I'm gone.' I was so strong. I was so happy."

It took two more months of therapy before Wendy found a job. Now, while she goes to work at a child-care center for the Navy, her children and her sister's go to school or another local child-care center. With her new salary, she has set herself and the children up in a new apartment. And a year into her group therapy, she plans to continue for as long as Miranda's program is operating. "My kids are so much happier," Wendy says. "They want to do things all the time now. We talk for hours every day. We read and do homework all together. We joke around. We all talk about careers, and before they didn't even think careers. I talk to them about drugs, and they've seen my sister, and they keep clean now. They don't cry like they used to. They don't fight like they did."

"I never thought I would get this far. It feels good to be happy. I don't know how long it's going to last, but I sure hope it's forever." She smiles and shakes her head in wonder. "And if it weren't for Dr. Miranda and that, I'd still be at home in bed, if I was still alive at all." Miranda says, "There are thousands of success stories as magical as this one, just waiting for appropriate interventions."

The treatments Wendy received did not include psychopharmaceutical intervention. What was it that enabled this metamorphosis? In part, it was simply the steady glow of attention from the doctors with whom she worked. In part, it was a cognitive shift. Miranda described Wendy as "clearly" having depression, but this had not been clear to Wendy even when she suffered extreme symptoms. The labeling of her complaint was an essential step toward her recovery from it. What can be named and described can be contained: the word "depression" separated Wendy's illness from her personality. If all the things she disliked in herself could be grouped elegantly together as aspects of a disease, that left her good qualities as the "real" Wendy, and it was much easier for her to like this real Wendy and to turn this real Wendy against the problems that afflicted her. To be given the idea of depression is to master a socially powerful linguistic tool. There are no people so starved for this vocabulary as the indigent depressed, which is why basic tools like cognitive group therapy can be so utterly transforming for them.

Many women in Wendy's situation would be even more expeditiously helped by pharmaceuticals. There are four impediments to such broadband treatment programs. The first is that the indigent populations who might be helped by medication have never really been identified. The second is that to be effective, antidepressant medications must be taken on an ongoing basis over an extended period of time. The lower people's education levels, the less likely they are to take a medication that does not have any immediately palpable effect when they take it. Such people are also unlikely to continue to take their pills once their symptoms have lifted. The third, of course, is cost, though in absolute terms it costs less to provide medication than it does to provide the social services that the indigent require. The fourth is a mode of transmission. Pharmaceutical executives to whom I mentioned all the above said they would willingly set up programs to discount medication for use in these populations if there were a way to convey it. "I simply didn't know that such a phenomenon existed on the scale you are describing," one executive told me. In the absence of government programs to facilitate the distribution of antidepressants to this population, however, even the most well-intentioned members of the pharmaceutical industry are stymied.

The privately financed Treatment Advocacy Center is the most conservative body issuing policy on treatment, and its position is that people whose condition can be improved through treatment should receive it whether they want to or not. It is their view that those who resist treatment place an unconscionable and unnecessary burden on society. The Bazelon Center for Mental Health Law, a nonprofit policy group at the other end of the spectrum, believes that commitment should almost always be voluntary and defines mental illness as interpretive. The A.C.L.U. takes the middle ground. It has published a statement that "the freedom to be wandering the streets, psychotic, ill and untreated, when there is a reasonable prospect of

effective treatment, is not freedom; it is abandonment" — though it also supports the right of people to make decisions about their own lives. The problem is that desperate people often dislike help because they do not believe that help will set them free. The answer is neither forced treatment nor abandonment; it is a process of forceful seduction predicated on the principle that those who are treated will be glad after the fact to have received such attention.

Joseph Rogers, the head of the Mental Health Association of Southeastern Pennsylvania, was indigent and depressed himself at one time; he spent a year living on a bench in Central Park before being drawn into an outreach program. "People who are isolated and lost are usually desperate for a little human connection," Rogers says. "Outreach can work. You just have to be willing to go out and engage them and re-engage them until they're ready to come with you." Rogers has helped to make Pennsylvania one of the most progressive states in the nation for mental health. In fact many people from neighboring states get shipped into Pennsylvania so they can take advantage of the systems there.

Rogers also has created a chain of what he calls "drop-in centers," which are street-level storefronts, usually staffed by people who are themselves recovering from mental illnesses. This creates employment for the people who are just beginning to cope with a structured environment, and it gives people who are in bad shape a place to go and receive advice. Drop-in centers provide a transit zone between mental isolation and companionship.

Popular wisdom holds that you need to address unemployment before you start worrying about the fancy business of the mental health of the unemployed. And greater prosperity is a good trigger for recovery. But it is perhaps easier and equally reasonable to treat the depression itself so that these people can alter their own lives.

Our failure to identify and treat the indigent depressed is not only cruel but also costly. Many of the depressed poor are welfare recipients who cannot hold jobs. They are given to substance abuse and other self-destructive behaviors. They are sometimes violent. Infants of depressed mothers show brain-wave patterns different from those of other infants, according to a study by Tiffany Field, chair of the Touch Research Institute. These altered patterns seem to relate to the closing down of essential brain circuits that, if they do not function in childhood, are probably inoperative later on. Treat the depression in the mother, and the infant's brain waves are likely to normalize. When a depressed mother is not treated, her children tend to end up in the welfare and prison systems: the sons of mothers with untreated depression are eight times more likely to become juvenile delinquents as are other children. Daughters of depressed mothers will have earlier puberty than other girls, according to a recent paper by Bruce Ellis and Judy Garber in the journal *Child Development*. And early puberty is usually associated with promiscuity, early pregnancy and mood disorders.

According to the 1998 Green Book of the House of Representatives Committee on Ways and Means, state and federal government spends roughly \$20 billion on cash transfers to poor nonelderly adults and their children, and roughly the same amount for food stamps for such families. If one makes the conservative estimate that 25 percent of people on welfare are depressed, that half of them can be treated successfully and that of that percentage, two-thirds could return to productive, at least part-time, work, factoring in treatment costs, that would still reduce welfare costs by as much as 8 percent — a savings of almost \$3.5 billion per year. Because the federal government also provides health care and other transfers for such families, the true savings could be quite a bit higher.

The dollar cost of interventionist treatment of depression is really quite small; the dollar cost of not treating depression is enormous. "Postponement of intervention does not result in savings," Representative Marge Roukema, a Republican from New Jersey and the co-chairwoman of the Working Group on Mental Illness, says. "You're really building in greater costs."

For more than a decade, Glenn Treisman of Johns Hopkins University has been studying and treating depression among indigent H.I.V.-positive and AIDS populations in Baltimore, most of whom are also substance-abusers. "Many people get H.I.V. when they can't muster the energy to care anymore," Treisman says. "These are people who are utterly demoralized by life and don't see any point in it. If we had treatments more broadly available for depression, I would guess from my clinical experience that the rate of H.I.V. infection in this country would be cut in half at least, with enormous consequent public-health savings."

Mental-Health Services are still focused primarily on the noisy disorders, with schizophrenia and mania at the top of the list. "Of course we want to help nonviolent mentally ill people just as much as we want to help violent ones," Roukema told me. "But to draw any kind of substantial support, we have to show people that it serves their urgent self-interest to do something about mental-health care for the poor. We have to talk about preventing atrocious crimes that could be visited on them or their constituents at any moment. We can't talk simply about a better and more prosperous and more humane state."

There is no discussion in Congress at present about depression among the uninsured. Senator Pete Domenici of New Mexico, who has been the joint sponsor of several important mental-health bills, says this situation is unlikely to change. "If you're asking whether we can expect much change simply because that change would serve everyone's advantage in immediate economic and human terms," Domenici says, "I regret to tell you that the answer is no."

It is hard to find anyone in Congress who is opposed on principle to healing the mentally ill. "The opposition is competition," says Representative John Porter, an Illinois Republican who until January was the chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee. Nonetheless, while declarations about the tragic nature of suicide and the danger of psychiatric complaints accumulate on the Congressional record, legislation pertinent to these statistics does not pass easily. "Progress here is excruciatingly gradual," says Senator Paul Wellstone of Minnesota, who has made regular attempts to introduce comprehensive legislation for mental-illness coverage. "The uninsured haven't even made it onto the radar screen around here yet."

There are programs, even some good ones, that are available to the poor mentally ill, but they exist inside hospitals. You have to find them yourself. Public-relations campaigns for treating mental illnesses — signs on buses, TV ad spots and so on — have had some success at bringing people into clinics, but the idea that indigent depressed people will ever have the wherewithal to seek and find help, even if they did figure out for themselves that they were depressed, is ludicrous. A program that did a basic mental-health screening at family-planning clinics or at job centers or at places where welfare checks are distributed might allow us at least to identify the people who are currently suffering from illness.

But the best place to start would probably be the welfare rolls. Major depression is frequently triggered by stresses, and there is no question that the lives of welfare recipients are extremely stressful. At the moment, however, welfare officers do no significant screening for depression. Welfare programs are essentially run by administrators, who do little or no actual social work. What tends to be noted in welfare reports as noncompliance is in many instances motivated by psychiatric trouble.

Some pilot studies are under way on the treatment of depression among the poor, and the results appear surprisingly consistent. I was given full access to subjects from several of these studies — some involved therapy, others medication, still others a combination of the two. To my surprise, everyone I met felt that his or her lot had improved during treatment. They felt better about their lives, and they lived better. Even when faced with insurmountable obstacles, they progressed, often fast and sometimes far. Over and over again, as I spoke to more poor people who had been treated for depression, I heard tones of astonishment. How, after so many things had gone wrong for them, had they been swept up by this help that had changed

their entire lives? "I asked the Lord to send me an angel," one woman told me. "And he answered my prayers."

O

BOOKS

FAR FROM THE TREE

THE NOONDAY DEMON

A STONE BOAT

THE IRONY TOWER

ARTICLES

DEPRESSION & SUICIDE

DISABILITY, HEALTH & DISEASE

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INTERNATIONAL REPORTING

MARRIAGE & FAMILY

VISUAL ART

MISCELLANEOUS

EVENTS

UPCOMING

SPEAKER'S BUREAU

ABOUT

BIOGRAPHY

COVERAGES

REVIEWS

LITERARY



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In October 2013, Maine Medical Center's Department of Vocational Services (DVS) began work on a contract with the Department of Health and Human Services, Office for Family Independence to conduct Vocational Assessments for ASPIRE participants. The assessment, which occurs over two separate sessions, gathers information directly from the participants to identify potential barriers as well as strengths towards becoming employed. The information is then translated into a report that identifies strategies for becoming employed. The report is completed within 20 days and submitted to the ASPIRE Specialist working with the participant; the ASPIRE Specialist reviews the report with the participant and provides them with a copy. A description of each tool is listed below.

Desire to Change

- The **Need for Change scale** asks two questions about the participant's desire to become employed and/or further their education.

Barrier Assessment

- The **Initial Assessment** asks 25 questions about physical and mental health, legal issues, and cognitive functioning.

Motivation to Change

- The **Rehabilitation Readiness Assessment** rates a person's interest in and commitment to changing their current situation. The tool includes assessment of self-awareness, environmental awareness, and the belief that change would be possible and positive.

Dysfunctional Thinking about Work

- The **Career Thoughts Inventory** has 48 questions which assess the degree to which a person has dysfunctional thinking related to career problem solving.

Domestic Violence

- The **Domestic Violence Screening tool** asks three questions about past or present physical, verbal, and sexual abuse.

Academic Screening

- The **CASAS Appraisal** is a math and reading assessment which identifies the level of instruction needed in further educational efforts.

Occupational Interest Inventory

- **My Next Move** is an online tool which is part of the federal O*NET system and matches a job seeker's skills and interests to jobs and labor market information.

Satisfaction

- At the end of the AVAP Assessment, the ASPIRE participant is asked to complete an anonymous five-question survey about the assessment process.

Of the individuals completing the first session of the assessment (1,591) by August 31, 2014, 1,392 (86%) are not employed. Seventy-nine percent of unemployed individuals reported a strong or urgent desire to become employed. Others are unsure or state they do not want to become employed.

Who are the unemployed individuals and what barriers to employment do they face?

Mental Health Status	Avg %	Detail		
		Urgent	Unsure	No
Experience periods of sadness or depression	63%	61%	73%	67%
Have received MH treatment in past	66%	63%	77%	74%
Currently receive MH treatment	27%	24%	37%	39%

Generational Poverty	Overall Avg %	Detail		
		Urgent	Unsure	No
Grew up in a household receiving public assistance	45%	44%	51%	41%

Substance Use & Abuse	% of total unemployed	Has been in treatment for substance abuse:	
Think they have a problem with substance abuse (N=146)	11%	N= 118	81%
Do not think they have a problem with substance abuse (N=1212)	89%	N= 196	16%

Primary Language other than English	11.7%	
Of those unemployed with a primary language other than English:	#	%
Have a stated strong or urgent need to work	134	84%
Are unsure about work	9	6%
Do not want to change unemployment status	17	11%

Domestic Violence	Overall Avg %
Has experienced some type of domestic violence (N=812)	60%
Currently in an abusive situation	3%
Knows about available services	85%
Reports it impacts ability to work	20%

Education Level	Overall Avg %
Did not graduate High School	23%
High School Graduate	43%
Some college/Adult Ed/2-yr degree	31%
Bachelor's Degree or beyond	4%

Referrals Received through August 31, 2014: 2838

1216 Assessments Completed

Identified need for
further clinical
assessment: 267

Pathway 1:
Work-Ready
(398)

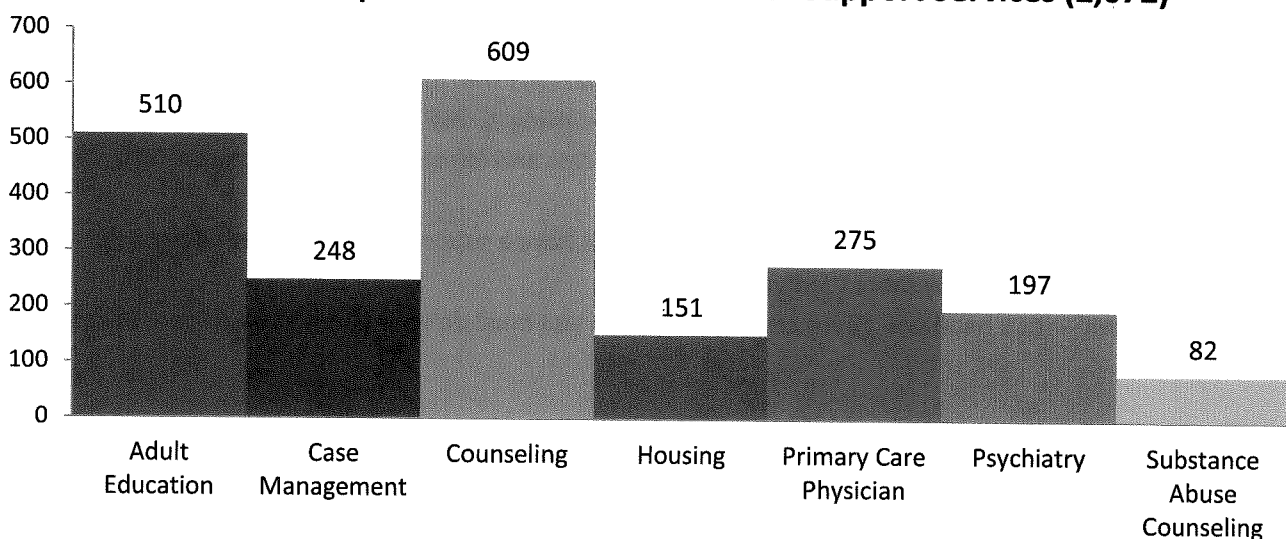
Pathway 2:
Skill-building and
work experience (496)

Pathway 3:
Intensive support
(322)

Each report to the ASPIRE Specialist identifies recommended services and resources to assist the ASPIRE Participant on their pathway to employment. **All participants receiving an assessment are recommended to utilize job search and/or support services from the best available resource:** Career Centers, Job Site Developers at Career Centers, Vocational Rehabilitation, Individualized Placement and Support at a mental health center, or assistance from a specialized TANF Multiple-Barrier Employment Specialist.

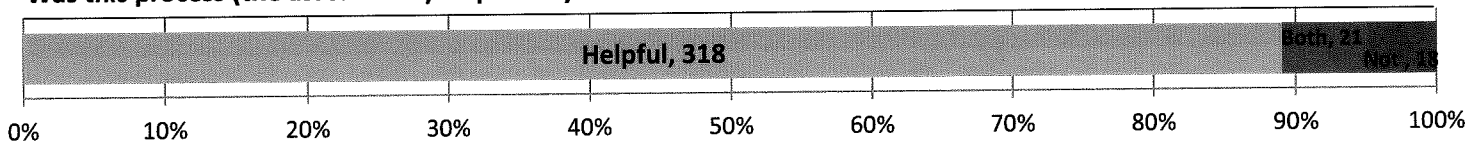
In addition, AVAP Employment Specialists identify support or treatment services that they have determined could be beneficial for the participant's future employment success.

AVAP Reports: Recommendations for Support Services (2,072)



Beginning in June, 2014, AVAP Employment Specialists began disseminating a survey to ASPIRE Participants completing the assessment. The survey, only five questions, is completed by the participant and anonymously returned.

Was this process (the assessment) helpful to you?



What was helpful?

- I learned a lot about myself and where I might go from here. Excited to use the Career Center to help me find a job.
- I remembered a lot more than I thought from high school and college. Gave me more confidence in my abilities.
- This was helpful to determine if you need a little more education to land a job and to also help you in the future.
- The program to help me find different job matches was great. I also like that it'll tell me what certifications I need (if any) and will tell me the closest city/town to get training.

What do you hope will happen next?

- I am going to go home and get back on the website My Next Move and hopefully get info on trainings and certifications and get started so I can go back to work!!
- I am hoping to find the resources and confidence in myself to realize my potential and find a more meaningful job.
- I hope to further my career and studies. Build a better life for myself & son.
- I hope to re-enter the workforce with excitement and courage.
- To get myself in a better place -- job & mentally.

What do you think the general public thinks about people on TANF?

- Honestly, they think we're moochers who like living off the state.
- I believe people think we don't want to work and want to mooch off the government.
- I believe they look at them as free-loaders or lazy individuals.
- That all they do is abuse it.

What do you want the general public to know about people on TANF?

- Everyone has their own story. Some people may be starting their life over or may have just been diagnosed with an illness that prevents them from working. We are individual persons with individual histories.
- It's important for people to realize what comes along with receiving it. ASPIRE is something many people lack knowledge of and if people were educated on the actual process and direction given to those on TANF they'd be more apt to think in a positive way about the whole ordeal.
- I am a regular person going through a hard time. Not all of us have a support system or want a hand out. Just a helping hand... I don't like it any more than you would.
- It is not a handout -- it's a hand up! There are guidelines and you must do your part and be diligent to receive the assistance.

10-15-14

provided by Jay Harper

Introductory Remarks for HHS Committee 10/15/14

Good morning and thank you for the opportunity to update you on the progress we are making at Riverview Psychiatric Recovery Center, as well as answering any questions you may have on our efforts.

Seven months ago Commissioner Mayhew asked if I would assume the position as Acting Superintendent of Riverview. Specifically she asked that I address three concerns of hers.

First, that I evaluate and establish an environment of safety for everyone; ... patients, staff, families and other visitors.

Second, that I create a recovery focused therapeutic culture at Riverview that is grounded in research, and best practices. That this culture be documented and lend itself to knowledge based decision making and practices.

Third, that the whole organizations move beyond minimum standards established by accrediting and licensing organizations to one of being a center of excellence.

Oh yes, she also asked that I direct the day to day management of the enterprise.

I believe that we have moved a substantial way along to achieve this first objective. Riverview now has a clear focus on safety and every employee understands and has been directed by me to maintain a focus on this concern. We have established a pattern of walking management that has executives and mid-level managers that previously had been isolated in an administrative structure, out on the operational floor of the Center. We have established a redundant reporting format for any act that challenges our zero tolerance standard for safety. Incident reports are completed as situations unfold. Reports are generated to nursing leadership which evaluates them at the morning meeting with me and the clinical managers. Independently reports are sent to our quality improvement section which has an investigator assigned to run down basic facts before the morning meeting begins. **(We are working to establish a second investigator position to facilitate the timeliness of review and response in this area.)** A third stream of information goes independently through operations center with the monitoring and review of over sixty cameras monitoring all patient common areas. **(We anticipate adding a further saturation of**

this technology in several areas of the facility.)

In addition to these organizational reforms we have also added the human element by expanding the number of our Acuity Specialists which I have spoken to you about in the past. **(We currently have eight Specialists and over the introduction and debate of the FY15 supplemental budget and FY16 & 17 budget we will be seeking to double this number.)**

Our second objective has required that we completely overhaul our treatment planning system both; records and practices. To this end, after many months with little traction in the conceptualization and design of the treatment planning process, we have in the past two months, finally been able to align our planning, record keeping and quality assurance system to meet the standards of CMS, DLRS, JACHO with our own desire to define recovery based interventions. We can now move from a consensus diagnosis to identified distractive or disruptive symptoms and behaviors to treatments and interventions while at the same time including and incorporating the patients perspective through exercise in personal medicine, enhanced peer support activities and more pro- active patient participation in treatment meetings.

This systems process is the backbone of what Riverview has been asked to do and it represents the basis for which we contract with CMS for the reimbursement of services. But beyond this major accomplishment we have built out our clinical teams in two areas: psychology and occupational therapy. With the augmentation of these two disciplines combined with our rehabilitation and recreational therapists we are constructing a holistic treatment design that will provide patients with the best array of skills for leaving Riverview and continuing on with their lives. We have made significant advances in this area but we have much more to do including the continued refinement of therapeutic interventions through Riverview's treatment mall concept and other community integration activities.

My third charge was to establish Riverview as a Center of Excellence in the care and treatment of Maine citizens with psychiatric challenges. Frankly this has been the most difficult of challenges. To move from a "just good enough" mentality to a center of excellence will require that all of the basic cultural and historical constructs around Riverview be challenged. To assist in this area we have enhanced our historical relationship with Dartmouth University for clinical and complex case assistance; we are engaging in discussions with Lesley College the Cambridge Health Alliance and Harvard University concerning the establishment of a core curriculum based on mindfulness, motivational interviewing and non-violent communication for the entire staff of Riverview; and we are significantly more active within the Maine Hospital Association to find out how we can partner more in both policy discussions and practices in order to enhance the impact of our limited resources.

All of these efforts must advance simultaneously with our desire to step up significantly our investment in our own staff. For the past several years little attention has been paid on staff and organizational development. Thankfully with your support we received an important down payment in this area. We anticipate not just bringing many of the trainings identified above to Riverview but to also partner with the University of Maine system and Maine's Community College to review and revise college based preparatory systems for the future employment at Riverview. These next few years will be very exciting times as I truly believe we will be able to achieve this third goal.

In conclusion I would like to thank you for all of your support during these very trying times and to identify for you two policy areas where I believe we need further investigation and resolution.

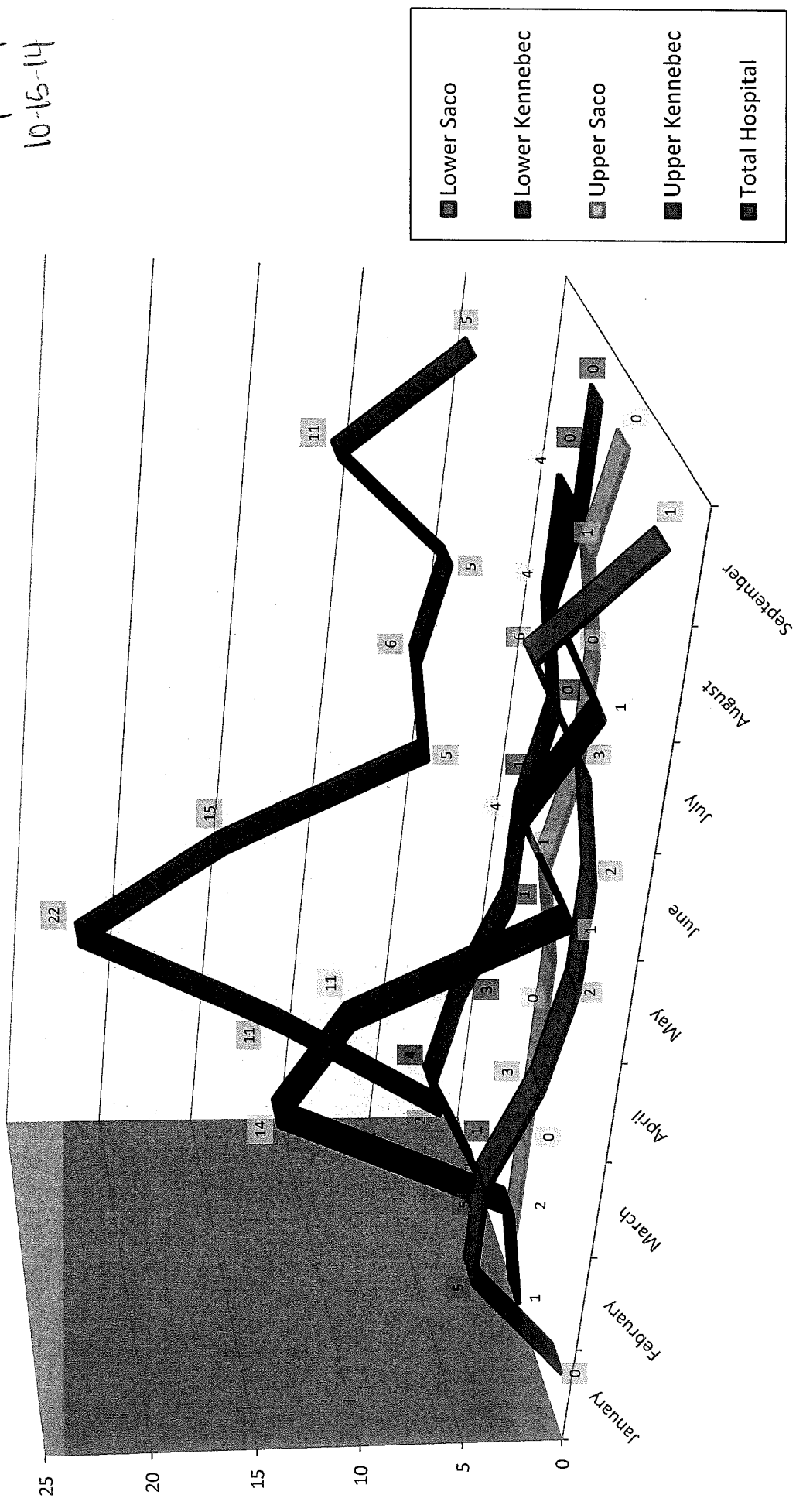
First we must clearly define the patient cohort that best matches the skill set of Riverview. Currently everyone can come to Riverview who has been suggested for admission by the court system. This has resulted in the challenge of violence within our walls.

Second we must face up to the stigma of psychiatric challenges in our own systems. When a staff member or patient is assaulted and we call for the police to support us and make an arrest we are denied this option that is available to every other citizen in Maine. The arresting and prosecutorial agents of the state treat this situation uniquely in our society. In any other venue an assault is an assault. The suspect is arrested and removed from the setting, justice proceeds and in a court of law with due process a determination is made as to the future of the individual. At Riverview the patient is left in place to assault, abuse or control others.

Thank you for your attention to these matters.

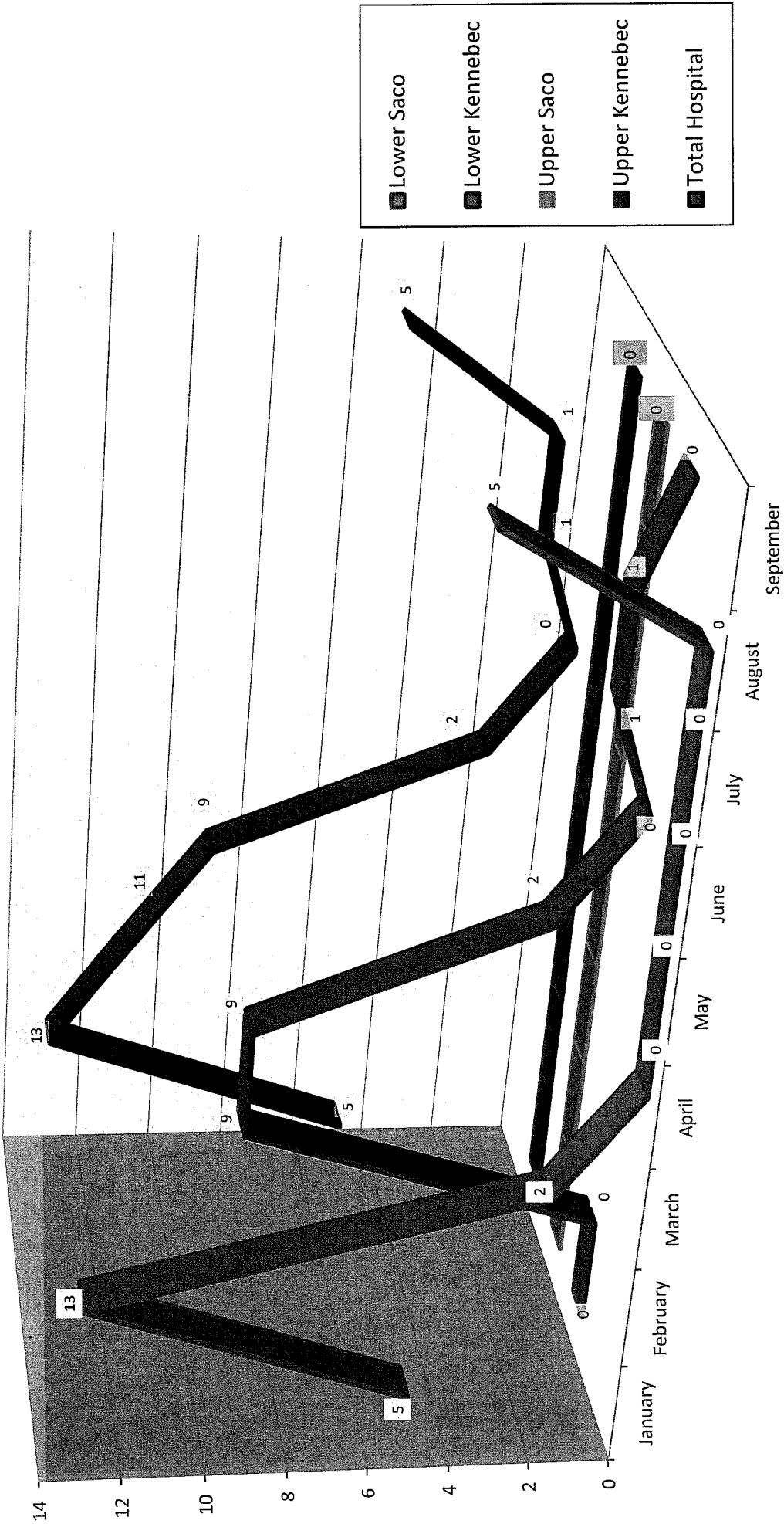
provided by
Jay Harper
10-15-14

Psychiatric Emergencies Chart by Unit, January 2014 –September 2014



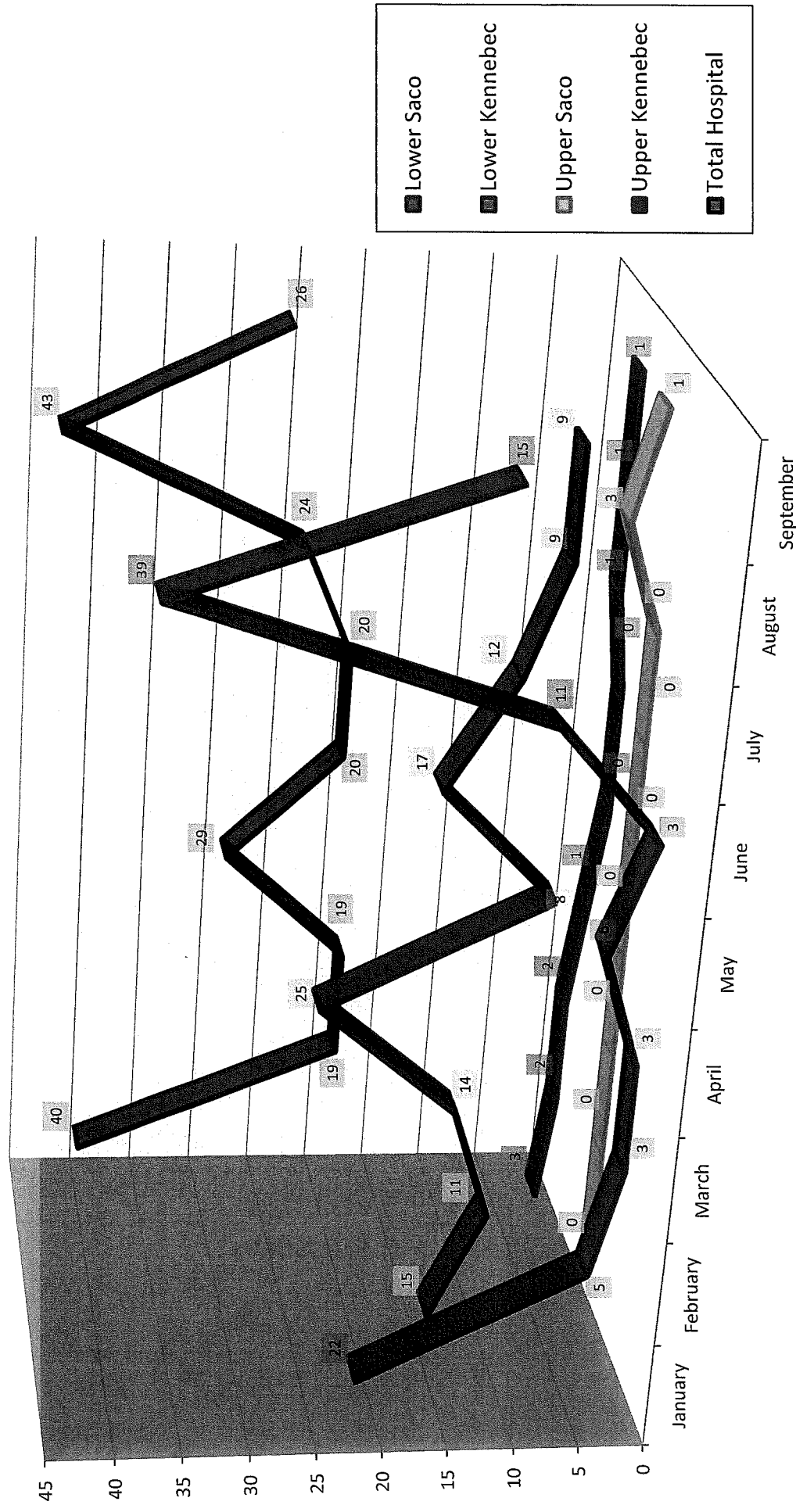
	January	February	March	April	May	June	July	August	September
Lower Saco	0	5	5	3	2	2	3	6	1
Lower Kennebec	1	2	14	11	1	4	1	4	4
Upper Saco	0	0	0	0	1	0	0	1	0
Upper Kennebec	1	4	3	1	1	0	1	0	0
Total Hospital	2	11	22	15	5	6	5	11	5

Restraint Events Chart by Unit, January 2014 -September 2014



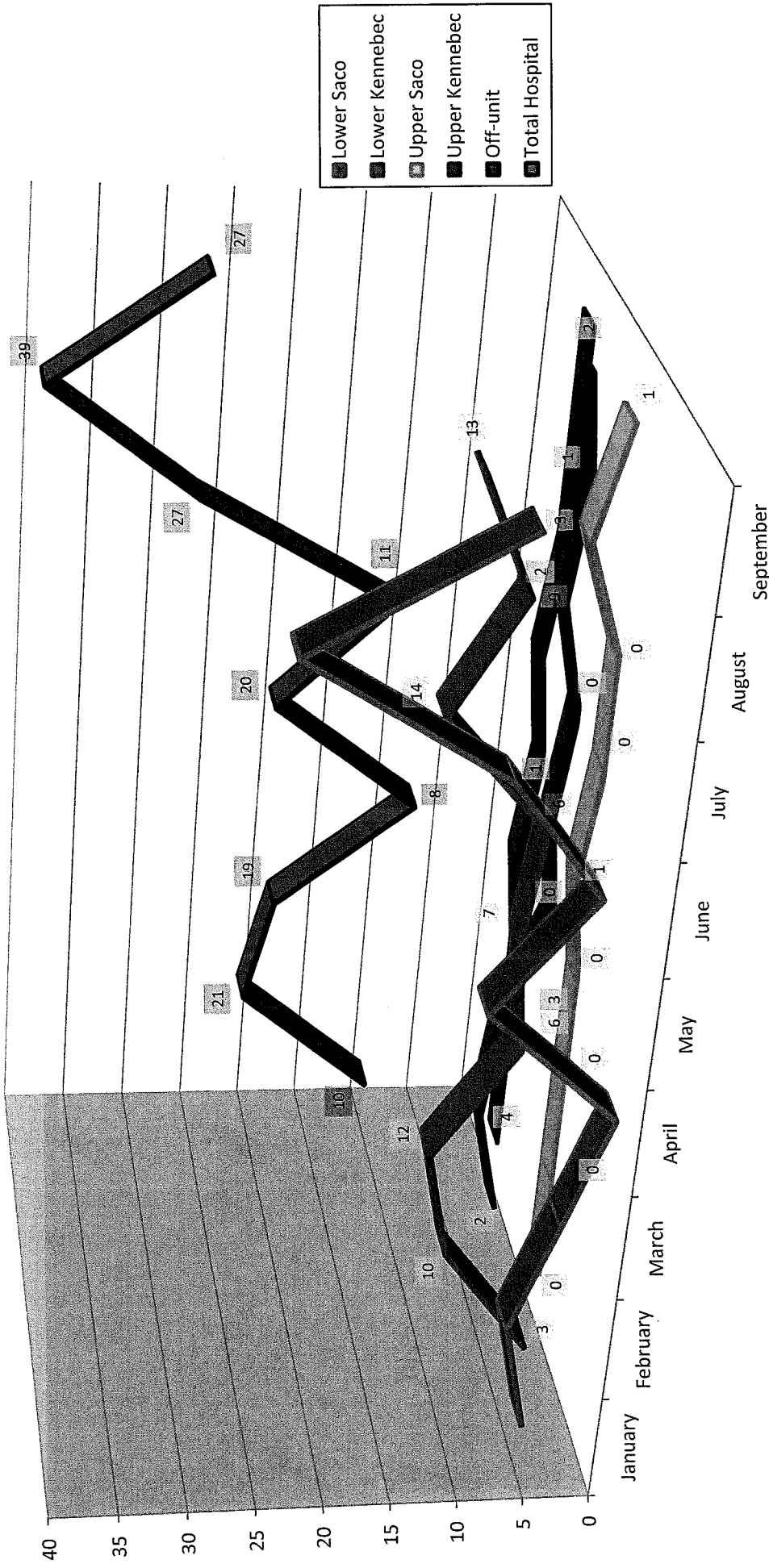
	January	February	March	April	May	June	July	August	September
Lower Saco	5	13	2	0	0	0	0	0	5
Lower Kennebec	0	0	9	9	2	0	1	1	0
Upper Saco	0	0	0	0	0	0	0	0	0
Upper Kennebec	0	0	0	0	0	0	0	0	0
Total Hospital	5	13	11	9	2	0	1	1	5

Seclusion Events Chart by Unit, January 2014 -September 2014



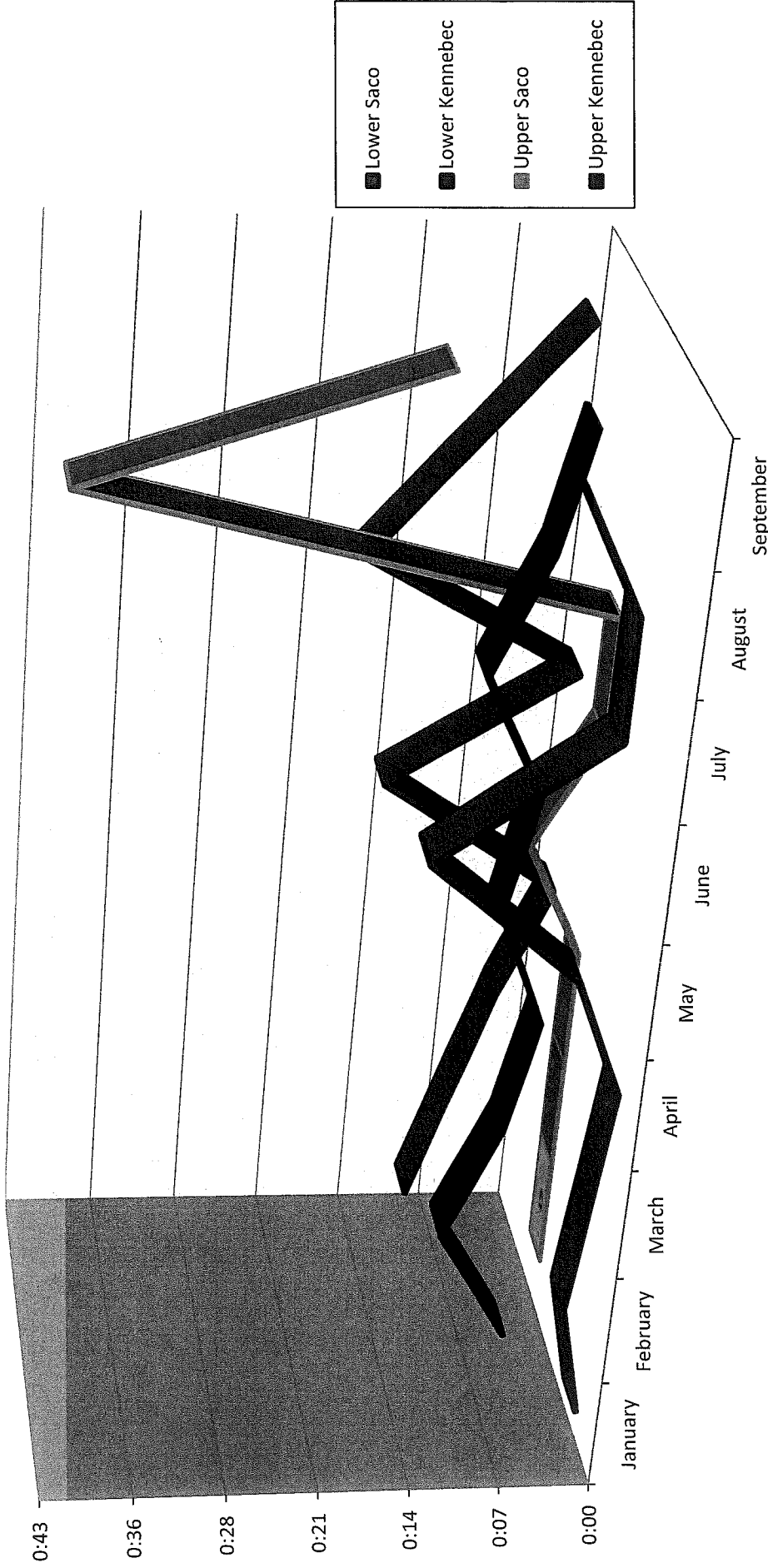
	January	February	March	April	May	June	July	August	September
Lower Saco	22	5	3	3	6	3	11	39	15
Lower Kennebec	15	11	14	25	8	17	12	9	9
Upper Saco	0	0	0	0	0	0	0	3	1
Upper Kennebec	3	2	2	1	0	0	1	1	1
Total Hospital	40	19	19	29	20	20	24	43	26

Number of Hands on Holds (HOH) by Unit, January -September 2014



	January	February	March	April	May	June	July	August	September
Lower Saco	5	7	4	1	11	4	11	26	11
Lower Kennebec	3	10	12	6	7	6	14	9	13
Upper Saco	0	0	0	0	1	0	0	3	1
Upper Kennebec	2	4	3	0	1	0	2	1	2
Off-unit	0	0	0	1	0	1	0	0	0
Total Hospital	10	21	19	8	20	11	27	39	27

Average Duration of Hands on Hold (HoH) by Unit, January 2014-September 2014
 (Value shown in minutes)



Average Duration of Hands on Hold (HoH) by Unit

	January	February	March	April	May	June	July	August	September
Lower Saco	0:01	0:03	0:02	0:01	0:05	0:17	0:04	0:04	0:09
Lower Kennebec	0:05	0:11	0:07	0:05	0:09	0:07	0:12	0:08	0:06
Upper Saco	0	0	0	0	0:05	0	0	0:42	0:01
Upper Kennebec	0:10	0:07	0:04	0	0:15	0	0:18	0:10	0:02

Remarks of Court Master
October 15, 2014

Senator Craven, Representative Farnsworth and members of the Health and Human Services Committee:

I have two principal concerns arising out of recent events at Riverview Psychiatric Center. First, I am concerned about the integrity of the reporting systems required by the Consent Decree, and secondly I am most concerned about the safety of the hospital, from the point of view of both clients and staff.

With regard to reporting, I have a bit more work to do, but at this point it seems abundantly clear that both the Department and advocacy groups have ignored the reporting requirements of the law and the Consent Decree with regard to patient abuse. This is a serious matter that I will address with the Court, and at this point, I am unable to speculate as to what the consequences might be.

My review of the current safety of the hospital included having Elizabeth Jones conduct a site visit at the hospital last week. You may recall that Elizabeth Jones is the person who was the court-appointed receiver of AMHI back in 2004 and operated the hospital successfully for a period of more than one year. In my view, she turned the hospital around at that time. Elizabeth spent two and one-half days at the hospital last week and visited all four units and spoke exclusively with direct care staff and clients during all three shifts. She and I met with the Commissioner at the conclusion of her visit last Friday and she conveyed her tentative impressions, which will be followed up with a detailed report to me in the next couple of weeks. I will make a copy of that report available to the Commissioner and to this Committee when it is received. Progress is being made at the hospital but my goal is to offer suggestions for improving the effort and insuring that the changes announced are actually being put into operation at the level of direct care.

At this point, I can only touch upon some of the highlights that I anticipate will be in Elizabeth's report. Obviously her report will speak for itself when it is received. First it is clear that the level of acuity presented by both the civil and forensic clients at the hospital is higher than it has been in the past. In part, this may result from the system that was established for civil clients several years ago whereby community hospitals and special psychiatric hospitals served as the gatekeepers for admissions to the two state operated psychiatric hospitals. Thus, Riverview currently receives as civil patients, only those who cannot be stabilized at either Acadia or Spring Harbor. Taken together with the growth in the number and acuity of forensic clients, this change in clientele necessitated changes in hospital staffing and those changes have not kept pace. To state it quite simply, this highly acute hospital requires staff that are the best of the best. We have some of those but not enough. I am sure that Elizabeth's report will recommend staffing by acuity rather than by the numbers; increased qualifications and training for direct care staff, particularly in the two most acute units; eliminating mandated overtime and shifts and eliminating the assignment

of inexperienced floating staff to acute units. Lower Saco and Lower Kennebec require a full complement of fully trained and highly experienced direct care staff.

Second, there appears to be some need to clarify the operating definition of Recovery as it is practiced at the hospital. Commendably, the hospital is seeking to reduce the use of seclusion and restraint but what will replace those responses in the event of assaultive and other problem behavior that does not warrant criminal prosecution? Recovery does not mean that the client gets a free pass, there has to be a system to hold people accountable for their actions. With clients rights comes responsibility.

Third, it is imperative that Lower Saco be reunited with the other three units of the hospital. This voluntary decertification developed out of the pressure created by the measures taken by CMS. As a result, Lower Saco, which contains some of the most acute and difficult clients at the hospital, has been separated from the balance of the hospital and thus the clients are deprived of treatment opportunities and recreational opportunities such as the gym. Their outside access is limited to four 15 minute periods a day in the exercise yard. Thus, we have a difficult population, bored, with nothing to do and limited access to active treatment. The limitations imposed on the clients housed in Lower Saco in terms of activities and treatment may very well, in and of themselves, violate the terms of the Consent Decree.

That is a preview of some of the issues that I expect Elizabeth will address in her report. In addition I have a few observations of my own. The events in recent months have persuaded me that in dealing with today's forensic population, the hospital must be authorized to resort to involuntary medication to the full extent permitted by the United States Constitution. Medication should be available both in terms of the danger presented by a particular client, and, in a limited number of cases, be available for the purpose of restoring competence for trial. I have asked counsel in the consent decree litigation to work with me to prepare draft legislation for your consideration in the next session.

In addition, we need to have broader access at the Mental Health Unit at Warren for forensic clients. Dangerous behavior is not confined to any particular segment of the forensic clientele. Admission to the Warren Unit should be possible for any forensic client who cannot be managed safely at the hospital. Finally, for now at least, after talking with numerous people in the last few weeks, I would stress that Riverview requires the appointment of a permanent supervisor as soon as possible; employees must be provided with a safe mechanism for reporting concerns about incidents in the hospital without fear of retaliation, and the hospital must develop a feedback loop that engages and captures the views, talents and abilities of all of the professions within the hospital.

I would be pleased to answer any questions.



MSEA/SEIU LOCAL 1989
65 State Street
P.O. Box 1072
Augusta, Maine 04330
622-3151/1-800-452-8794

DATE: October 15, 2014

TO: Senator Craven, Representative Farnsworth and members of the Joint Standing Committee on Health and Human Services

FROM: MSEA-SEIU, Local 1989

SUBJECT: Riverview Psychiatric Center Health & Safety Survey Summary & Survey

This survey was undertaken by MSEA to gather information on what Riverview employees identified as important approaches to take to improve employee safety on the job. The survey respondents totaled 43, and came from the ranks of RNs, LPN, Maintenance Worker, Social Worker, Ward Clerk, Acuity Specialist, and Mental Health Workers (AFSCME members). All but one person who completed the survey responded to the first question: *Have you ever been physically threatened, attacked, or injured at work?* While 5 employees responded, “No,” **37 employees responded, “Yes”--and of these 37, 16 employees required medical attention.**

Below are concerns and suggestions put forth by Riverview employees to identify and address health and safety issues:

Changes in workplace configuration:

- Locks on half doors
- 2 exits
- No moveable furniture (chairs, baskets, night stands, file cabinets)
- Hot water can be used as a weapon
- No closed rooms
- Enclose nurses station
- Remove wall so nurse can see while documenting—replace with lexan for privacy and safety
- Remove part of wall so nurses can have line-of-sight on the unit
- Every unit needs SRC
- Concrete walls in the SCU area instead of sheet rock
- Back door from every nurses station directly to hallway so patients can’t monitor the number of staff on unit
- Remove fish tank
- Solid concrete floors with drains in client bathrooms (tiles have been broken for weapons)
- Doorways should not have set-in walls
- Duress pagers are too heavy to wear comfortably on neck, bulky

- Need more duress pagers

Camera blind spots identified

- Lower Saco for recording events in North and West Wings (reported at Labor Management meeting)
- Need camera at end of the West Wing
- Blind spots on main unit and SCU on Lower Saco
- Stairwells and elevators
- Nurses work area (understand need to do this within HIPAA)
- Laundry room
- Ante room
- South Wing
- Safety Officer could inspect each unit to assess for blind spots.

Do employees work alone or in secluded places? If so, when?

- Outside appointments that need coverage
- In-hospital appointments that need coverage
- Escorting clients in stairways and on elevators
- Laundry room
- MHWs take patients downstairs for fresh air breaks
- Improvements—4 MHWs per unit evening, 5 day, 3 overnight

Calling for help

- “Unsure of procedure to call police—it’s always changing.”
- Can we actually call Capitol Security directly if we need to? If not, why are they in the building?
- RNs in Med room can’t hear a staff in distress.

Recommendations to provide adequate alarm system

- Beepers are constantly going off for connection errors
- Pagers should be available to staff
- Pagers should be used in emergencies—not for weather updates
- Panic buttons sometimes haven’t worked
- There is no indication that the duress pager is working.
- Need to more quickly identify where emergency is with pagers
- New systems—such as dedicated cell phones with speed dial
- Overhead audio alarms for emergencies will assure rapid responses.
- Cell phones are currently prohibited from being carried by direct care staff—change this.
- Should have a “man down” system for panic buttons
- Panic buttons that work
- Sound systems which can be heard by all staff
- Beepers should not be taken home by employees
- Duress pagers are too heavy to wear comfortably on neck, bulky
- Metal detectors need to work

Staffing

- Need sufficient staff to respond to STATs while maintaining enough staff on unit

- Minimum Staffing ratios/levels are needed
- Adequate staff to maintain proactive atmosphere (as opposed to reactive atmosphere we have now); by the time help arrives, someone is often already injured.
- If you have several clients asking for things, staff become busy. Factor in breaks—and it leaves the floor bare (especially at night).
- Need one nurse on the floor at all times; the number of MHWs needs to be increased
- There are times when staff is on rounds without an observer at the desk—despite the practice being discovered.
- Staff goes to the back room to document since there is no capability where patients are being monitored.
- Eliminate staffing by mandate—staff working 16-hour shifts are often in no condition to be effective/therapeutic.
- 12-hour shifts—especially night would allow better recovery times between shifts
- Need a buddy system
- On-call staff needed
- Reinstate requirement for CNA for MHW
- There should be a staff member assigned to only watch the desks, halls, cameras— with a whistle. They don't move until someone else has the whistle.
- Policies and guidelines should be clearly defined and accessible.
- Need process in place to move violent patients to jail.
- RN needs to be visible to supervise ancillary staff and provide direction and facilitate safety.
- Every unit and shift should have an acuity specialist.
- New staff should have mentors.
- All staff should be trained as acuity specialists.
- Pay increases for all those who work at Riverview.
- Mandating staff should be the exception—RPC should hire and staff appropriately to create a safe environment.
- Stop trying to do more with less staff

Training requested

- MOAB—with refresher classes
- How to handle and report bullying .
- How to help nurses when giving injections.
- Situational awareness
- Unit policies and guidelines—examples: bedtime, dietary allowances (snacks), laundry time, client privileges
- Unit guidelines and rules in line with policy
- Appropriate boundaries between staff and clients.
- Management of aggressive behavior through verbal de-escalation techniques using anecdotal situations that have actually happened.
- Staff competent in handling clients who decompensate and maintain appropriate boundaries with clients.
- Client safety from clients
- Communicating and working with mentally ill
- Personal defense training appropriate for workers in a psychiatric hospital
- TCI
- Santori

- Active listening skills (listening to patients, listening to workers)
- Horizontal violence
- Discuss ways to improve new employee orientation with staff
- Team-building exercises
- CNA training for MHWs
- Mandatory education for front-lines staff
- Stop the decrease in training; provide more training, not just a packet of questions; bring in trainers from outside the hospital.
- Make it possible for staff to attend trainings

Training for acuity specialists

- Mental health education
- They should be trained as educators and train other staff; work as resources and clinical leaders.
- An acuity specialist was injured when hands-on hold should have been required before the assault.
- Suicide prevention
- Help to de-escalate
- Communication and psychology classes
- Should carry bite gloves and restraints
- Concerns raised about difference between the way forensics patients and others think and respond.
- Weekly meetings to review past week

Recommendations for workplace violence prevention program

- Staff is exposed to disrespectful behaviors from patients and peers because it is tolerated.
- The nurse's station should be safer with barriers that cannot be jumped and workspaces where patients can be watched

Staff development and recognition

- Pay for conferences, national meetings, and other opportunities for staff development.
- Recognize staff for training, degree completion
- Celebrate staff doing good work—press

Maine State Employees Association Riverview Health and Safety Survey

I WORKPLACE SAFETY

1. Have you ever been physically threatened, attacked, or injured at work? YES NO
If so, did you require medical attention? YES NO

If you were attacked, what do you believe contributed to your injury (check all applicable)

- ☐ Established staff/patient ratios
☐ Placement of staff
☐ Understaffing
☐ Lack of training
☐ Patient access to things which can be used as weapons
☐ Other :

If so, what was the length of time it took for you to get assistance?

2. Do you need any of the following safety-related items to have and maintain a safe work environment?

- ☐ Equipment
☐ Clothing
☐ Devices or tools

If so, please list them:

3. Do you have a clear idea of who (and how) to call for help in an emergency?
YES NO

If no, what should be clarified?

If yes, what is your understanding of the process?

4. Are there changes in the way the workplace is configured which are needed to maximize the ability of an employee to escape in the event of workplace violence? (For example- 2 exits, furniture arranged to avoid entrapment etc.
YES NO

If yes, what are they?

5. If any of the alarm systems listed are inadequate, please check that line:

___ Panic buttons ___ Beepers ___ Cell phones

___ Surveillance cameras ___ Public address system

If not adequate, what do you recommend be changed?

6. If camera placement where you work is not sufficient to record activities on your unit, where are the blind spots?

7. Do employees work alone or in secluded places with patients, including stairways and elevators? YES NO

If so, what do you recommend be changed to provide adequate staffing?

8. Is there an effective workplace violence prevention program? YES NO

If not, check those it should include:

___ Zero tolerance policy ___ Engineering controls

___ Alarms ___ Handheld metal detectors ___ Closed circuit video

___ Furniture arrangement ___ adequate staffing, not working alone

___ Develop workplace violence training

Other:

9. The 9/21/14 Maine Sunday Telegram article said that “some patients are allowed to refuse medications and can be left in a psychotic state for up to a year.” What is your reaction?

II TRAINING

1. Would you like additional training to be safer at work? YES NO
2. Should training include improved communications between staff and patients?
YES NO

If you have other ideas for additional training needs, what are they?

3. Do you believe that the acuity specialists are getting the training needed?
YES NO

If not, what additional training should acuity specialists receive?

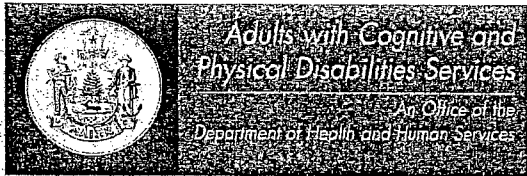
III SUGGESTED CHANGES

Are there structural changes which you recommend be made at Riverview?

Are there procedural changes which you recommend be made at Riverview?

Are there policy changes which you recommend be made at Riverview?

What other ideas do you have for making Riverview a safe place for employees and patients?



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

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Adults with Cognitive and Physical Disabilities Services
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11 State House Station
Augusta, Maine 04333-0011
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December 17, 2012

TO: Joint Committee of Appropriations and Financial Affairs
Joint Committee of Health and Human Services

FROM: Jim Martin, Associate Director, DHHS, Office of Aging and Disability Services

RE: LD1816; Section W-1; Adult Developmental Services Work Group

Dear members of the joint standing committees,

I'm writing today to provide you with the second update to the work being performed by the Adult Developmental Services Work Group. As you are aware, this work group was set forth in LD 1816, Part W, and I've been functioning as the facilitator.

As a reminder, members of this group include representatives from Speaking Up For Us (SUFU), Maine's Family Coalition, Maine Association of Community Service Providers (MACSP), DHHS, Maine's Oversight and Advisory Board (OAB), Developmental Disabilities Council, the Disabilities Right's Center (DRC) and community providers.

For this update, I would like to present two documents (attached) that have been developed by the work group. I have also attached a third document that has been shared by our partners within the Family Coalition. The first document is a narrative overview of the broad vision that this group shares. The second and third documents are a set of areas and goals that we feel require further development. Please take the opportunity to review these documents as they are the first attempt by this group to initiate change.

We have focused our efforts on creating a common vision that will provide the platform necessary to reach the salient points of the legislation. This is most obvious by reading the three attached documents. Community inclusion, self-determination and dignity of risk are at the center of our proposal. We feel that each person served within Maine's system should be allowed the opportunity to transition effectively through to adulthood and into the community where he or she will access natural community support and receive the formal support necessary to achieve autonomy and community inclusion.

Please feel free to ask questions or to identify further areas that we should discuss. Thank you for your time.

Jim Martin
Associate Director of Finance and Community Partnerships
DHHS, Office of Aging and Disability Services

LD1816 Developmental Services Lifelong Continuum of Care – Vision and Goals

Vision: Each person served within Maine's Continuum of Care will transition effectively through to adulthood and into the community where he or she will access natural community support and receive the formal support necessary to achieve autonomy and community inclusion.

Area 1: Assessment

Goal: Each person will receive a strength-based standardized individualized assessment (currently the Supports Intensity Scale) of his or her strengths or needs, which will inform the person-centered plan. This assessment will take into account all of the domains outlined in the Continuum of Care diagram.

Goal: Each person will be assessed for the natural support potentially available to them, and efforts will be made to maximize all of these as opportunities. This includes family, neighborhood, peers, and support networks. Each person should first access generic support and services that are available to everyone before disability-specific supports are considered.

Area 2: Service Delivery and System Navigation

Goal: Maine will establish a broad menu option model designed to match the amount and kind of paid support services needed by each individual.

- Maine will provide choices that accommodate everyone. These choices will address the need for a variety of models and ongoing adaptability to life changes or greater independence. This is the opposite of a one size fits all approach.
- Each person will also have a single point of entry that will be a gateway to all of the services needed.

Goal: Each person will have a designated Community Resource Assistant whose job it is to help an individual at any age navigate the local available array of services. This person would know the community and be willing to use relationships to open doors, and to connect with appropriate additional services or support. The Community Resource Assistant connects the person with services and opportunities on the ground including those in the following categories:

1. Community Inclusion and Self-Determination. The Community Resource Assistant will work to repair the divisions/breaks in community that still create exclusion.
2. Continuing Education. School will prepare an individual for transition to community and continued maximum inclusion through lifelong learning, creating true preparation for belonging and actual community participation at the fullest potential.
3. Natural Community Supports. The Community Resource Assistant will keep the support at the community level to foster natural supports. As part of the Person Centered Plan, the roles of all natural supporters will be formalized.

Area 3: Information Dissemination and Planning

Goal: Maine will ensure a thorough and accessible Information Repository. Maine will enhance information dissemination so that it is thorough and constantly updated, and how services work and are accessed will be transparent.

Goal: Maine will establish early support and planning about steps awaiting the individual and their transition to and through adulthood. Beginning at the moment the child is identified as potentially needing some type of unique support, there will be early intervention with a constant eye toward community integration

and adulthood success. Collaboration will occur in all systems so that planning for transition is lifelong and comprehensive.

Throughout elementary and secondary education and beyond, efforts to support success in the community will be fostered so that education and social activities are all part of engaging and developing skills and natural supports that continue through the lifespan. All decisions regarding the future will be founded on self-determination and individual personal choice.

Area 4: Community Inclusion

Goal: Maine will have a formal effort within each neighborhood or community to educate, foster inclusiveness, awareness, and an “it takes a village” mentality. Each community will form a casual safety and support web. Individual Service Plans will include the management of risk, including contingency plans (around personal crises, fires, disasters, etc.). Maine will enhance the community side of the equation. Like crime prevention strategies such as neighborhood or community “watch” locations, this effort will encourage or enhance neighborly activities that make up a safer and better-connected society for everyone. All individuals will function as a natural part of every community in which they live, work, and thrive.

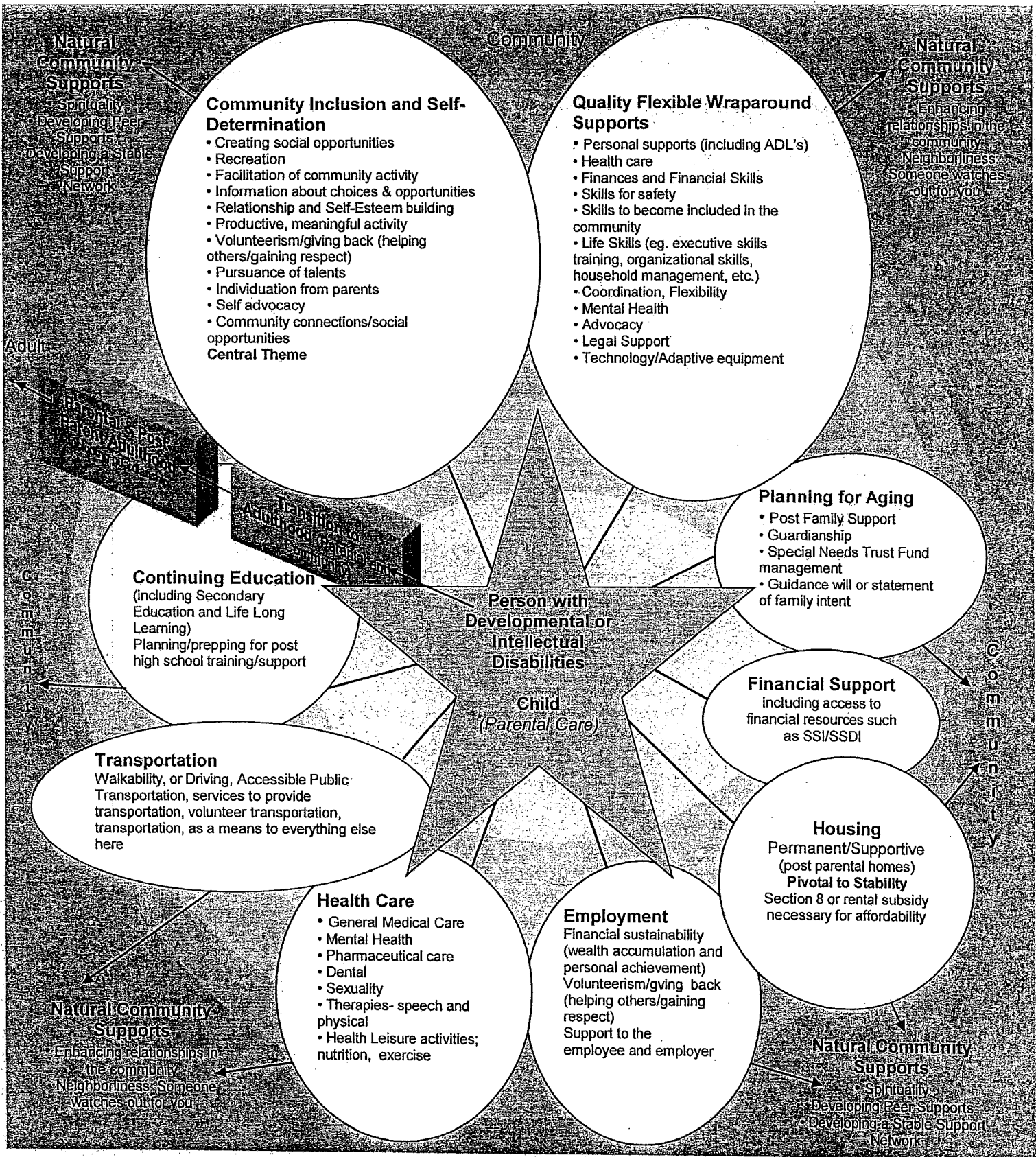
Area 5: Common Sense Service Delivery

Goal: Maine’s Developmental Services will deliver only the paid services needed; nothing more, and nothing less. Implementation will be regularly examined so that any inefficiency can be eliminated. A Stakeholder Working Group will receive input and participate in policy decisions about real life situations/policies to continue to examine the most efficient and effective use of resources.

1. This Working Group will evaluate new methodologies or technologies that can be incorporated for success. This group would then make recommendations to improve the menu of services. They would recommend how each service can be delivered in the most efficient and effective manner. There will be regular examination of available technology to see if it can be incorporated into the achievement of goals.
2. This Working Group will regularly examine the balance of established protocols vs. acceptance of risk, i.e. one individual may accept support during the day along with very limited support during the night knowing there may be some risk associated with limited night staffing, but the trade off is acceptable to the person. This also applies to community risk – the person may engage with and make errors within society, but will have maximum opportunity to freely engage, and will have at least a safety net to avoid catastrophe. Each person would have presumed competence allowing the “dignity of risk” that comes with independence in society.
3. This Working Group will regularly examine developmental services through the lens of how the rest of the world functions. Generic goods and services available to enhance everyone’s lives should be applicable to everyone in society. In this sense, individuals with developmental services needs are quite the same as everyone else. Specialized services should only be looked to when generic services alone can’t support the achievement of the individual’s goals.

Goal: Formal services will be based on individual and realistic needs, not on formulaic policies. Services will be flexible with only the necessary amount of paid support services. There will be no “one size fits all” approach. The formal delivery system will become nimble and flexible to allow for changes in a person’s functioning, and it will minimize obstacles to flexible adaptation. This will eliminate the need for people to fit into “categories” so they can receive services/housing – all will receive what they need at a level appropriate to them at any point in time, whether that increases or decreases. Maine will meet each person where she or he is.

DD Continuum of Care Diagram



LD 1816 Developmental Services Lifelong Continuum of Care Narrative

The model proposed in this document puts the person in the center. It highlights transitions across the person's lifespan and maximizes the use of natural support and community inclusion.

Community inclusion and self-determination are based on the assumption that the person is a part of and connected within the community. It means the person is engaged socially, recreationally, culturally, and spiritually. The person is a productive and valued community member, pursuing talents and giving back to others. The person individuates from parents and caregivers, makes informed choices, and is respected through typical interactions with others as part of a community. The person belongs.

People with intellectual or developmental disabilities rely, like everyone else, on family, friends, neighbors, and local support like public transportation, public recreation, church, and medical professionals. Individuals with disabilities often need added support due to unique challenges at various times in the lifespan.

When considering support, we want to look first for local, informal support. Only where there are gaps should we add in supplemental formal support to maximize independence, self-reliance, choice, and dignity of risk. Any supplemental formal support, such as those required for unique or complicated medical conditions, must be flexible and designed to meet the person where he or she is. Support may ebb and flow over the lifespan as the individual's needs change. Quality flexible wraparound support means varying services as needed (from minimal to maximum) to promote personal development, safety, stability, and inclusion.

The series of circles in the diagram to follow describe various needs for the person throughout their lifespan. Of these circles, community inclusion, employment or related activity, and housing stand out. Quality flexible support stands in the background rather than being a central focus. Beyond that, various circles gain prominence based on each individual's unique needs. Natural community support becomes the backbone of each person's autonomy and independence.

The rest of the circles are self-explanatory: Stable housing, transportation, employment, healthcare, financial support, continuing education, and planning for aging, all allowing community inclusion and self determination – central to the person's life.

Transition presumes that the person begins as a child under parental care, transitions to adulthood, and thrives in a world where community support, as needed, is present as part of a responsive support network. This requires an individual, family, community, and government partnership, where support for any individual is not artificial but closest to "typical" for anyone.

